X2016-1581

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET KIRKLAND, WA 98034

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L 000	INITIAL COMMENTS STATE HOSPITAL LICENSING SURVEY This State Hospital Licensing Survey was conducted on 7/11/2016 - 7/14/2016 by Cathy Strauss RN, Alex Giel, REHS,PHA, and Tyler Henning PHA. The Washington Fire Protection Bureau conducted the fire life safety inspection. During the course of the survey, surveyors assessed issues related to complaint 2016-7656 and 2016-7798. There were no findings under WAC 246-322. The complaint was not substantiated. ASE #2T2Q11	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 8/17/2016. 4. Return the ORIGINAL REPORTS with the required signatures.	
L 380	322-035.1P POLICIES-EQUIP MAINTENANCE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (p) Cleaning, inspecting, repairing and calibrating electrical, biomedical and therapeutic equipment, and documenting actions; This RULE: is not met as evidenced by:	L 380		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 8/10/16

STATE FORM 021109 | 2T2Q11 | If continuation sheet 1 of 17

Plan of Correction received 8-16-16 > Extension to 8-30-16
Plan of Correction approved 8-17-16

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L 380	Continued From Page 1 Based on observation, interview, and document review, the hospital failed to ensure that preventative maintenance was performed on all biomedical and patient care equipment within the facility. Findings: 1. On 7/12/2016 at 9:00 AM, Surveyor #1 and Surveyor #2 observed vital sign measurements on patients on the 2nd floor of the West Wing. The last preventative maintenance on the machine expired on 6/1/2016. The preventative maintenance logs indicate that preventative maintenance was due for all biomedical and patient care equipment on 6/1/2016. On 7/12/2016 at 9:00 AM, the facilities supervisor (Staff Member #7) said that the technicians were scheduled to come, but delays had pushed maintenance past the expiration date. 2. On 7/12/2016 at approximately 10:45 AM, Surveyor #1 and Surveyor #2 observed the laboratory room for use by the contracted service. The last preventative maintenance indicated on 2 centrifuges used for processing patient blood samples was from 10/2012. The facility was unable to obtain records indicating that the contractor had performed any preventative maintenance or calibrations.	L 380		
L 460	322-040.8B ADMIN RULES-PRIVILEGES WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (b) Delineation of privileges; This RULE: is not met as evidenced by:	L 460		

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L 460	Continued From Page 2 Based on document review, the hospital failed to ensure that the medical staff and governing body were approving or denying requested clinical privileges per their bylaws for 1 of 4 staff members reviewed (Staff Member #6). Findings: 1. The Medical Staff Bylaws state in part, " 7.2.4. Procedure: All requests for Clinical Privileges shall be evaluated and granted, modified, or denied ... " The Board of Governors Bylaws state in part, " Article XII.3.c. Governing Board Action. The Board shall consider the recommendations of the Medical Staff so presented and appoint to the Medical Staff ...Healthcare Professionals ...and shall assign to them appropriate staff status as well as clinical privileges ... " 2. On 7/12/2016 at approximately 3:00 PM, Surveyor #1 and Surveyor #2 reviewed medical staff documents. Of the 4 staff members reviewed, 1 Physician (Staff Member #6) did not have requested clinical privileges approved or denied by the medical staff or governing body. The medical staff and Medical Executive Committee signed the privileging form, but the governing body did not sign the form. In addition, the check boxes to indicate if requested privileges were approved or denied were not marked.	L 460		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which	L 690		

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L 690	Continued From Page 3 includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: Is not met as evidenced by: Based on observations, interview and review of policies and procedures the hospital failed to ensure staff members followed the hospital policy for hand hygiene. Findings: 1. The hospital policy titled " Hand Hygiene", (Policy #1600.4.4, Rev. 11/2015) states in part, " 1. Employees are required to wash hands thoroughly: 1.3. Before and after each individual patient contact. 1.4. After contact with potentially contaminated surfaces". 2. On 7/11/2016 at 3:00 PM, Surveyor #3 observed the Charge Nurse for West (Staff Member #1) unit deliver medications to 3 patients at the medication room med counter. No hand hygiene was noted between the patients medication delivery. Staff Member #2 did use soap and water when s/he completed med pass for the third patient. 3. On 7/12/2016 at 8:30 AM, Surveyor #3 observed the medication nurse on the South Unit (Staff Member #2) deliver medication to 3 consecutive patients. An automatic blood pressure/temperature machine was positioned near the medication counter and was used on the 2nd patient. Surveyor #3 observed the med nurse (Staff Member #2) administer medication to the 1st patient without performing hand hygiene	L 690		

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L 690	Continued From Page 4 before or after the medication pass. The 2nd patient to the medication window received a set of blood pressure and temperature monitoring and then was given the prescribed medication. No hand hygiene was observed prior to or following the medication pass. The patient care equipment was not sanitized after use. The 3rd patient received the medication pass without hand hygiene prior to or following contact with the patient. 4. On 7/12/2016 at 8:30 AM, the Chief Nursing officer confirmed to above observations 5. On 7/12/2016 at 9:00 AM, Surveyor #1 and Surveyor #2 observed a housekeeper (Staff Member #8) performing a terminal room cleaning in the West Wing of the hospital. S/he failed to perform hand hygiene following glove changes after contacting potentially contaminated surfaces. 6. On 7/12/2016 at 10:25 AM, Surveyor #1 and Surveyor #2 observed a Licensed Practical Nurse (Staff Member #9) administer medicine to patients in the West Wing of the hospital. S/he did not perform hand hygiene between patients.	L 690		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: Is not met as evidenced by: Based on observation, document review, and policy and procedure review, the facility failed to provide a clean environment for patients. Findings:	L 780		

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L 780	Continued From Page 5 1. The hospital policy titled " Terminal Disinfection of Patient Rooms" (Policy #1600.7.11, Rev. 11/2015) states in part, " 7. Spot washes walls, light switches, door knobs and other areas that the patient or staff may contract frequently. " The document provided by the environmental services contractor titled " OpenWorks PREMIER WORK SCHEDULE (Exhibit A) for Fairfax Hospital " states in part, " Patient Rooms, Wash/wipe walls as needed to remove spots - 7/W. Spot clean walls - 7/W " and " Bathrooms and Shower/Tub, Clean and disinfect shower walls, floors, and ceilings - 7/W. Dust all air diffusers - 1/W. " 2. On 7/11/2016 at 3:00 PM, Surveyor #1 and Surveyor #2 inspected a patient room (Room 111) in the North Wing of the facility. Stains and cobwebs were visible and were covering portions of the walls in the corner of the room near a patient bed and above the doorway. 3. On 7/11/2016 at 3:00 PM, Surveyor #1 and Surveyor #2 inspected a patient bathroom (Room 111) in the North Wing of the facility. The surveyors observed pink and white mildew covering the lower portions of the shower stall and the wall adjacent to the shower. 4. Surveyor #1 and Surveyor #2 observed multiple air diffusers and vents covered with dust. The observed rooms included 918 in the West Wing and 111 in the North Wing. 5. On 7/12/2016 at 9:00 AM, Surveyor #1 and Surveyor #2 made the following observations during a terminal room cleaning procedure in the West Wing (Room 918),	L 780		

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L 780	Continued From Page 6 a. The housekeeper (Staff Member #8) performed high dusting of surfaces after s/he had wet mopped the floor with disinfectant. This order of cleaning could introduce contaminants to the recently disinfected floor. b. The housekeeper cleaned the inside of the toilet bowl with a brush and proceeded to clean the sink basin with the same brush. c. The housekeeper placed a cleaning rag that was used to clean the patient room into the disinfectant solution bucket, potentially contaminating other clean rags.	L 780		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (I) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; This RULE: is not met as evidenced by: Based on observation, the facility failed to ensure that patients were provided with a cleanable mattress Findings: On 7/11/2016 at 2:30 PM, Surveyor #1 and Surveyor #2 observed a torn mattress in the South Wing (Room 405) of the facility. The mattress had multiple tears and abrasions that would prevent	L 880		

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L 880	Continued From Page 7 proper cleaning from occurring.	L 880		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This RULE: is not met as evidenced by: Based on observation, interview and policy and procedure review, the facility failed to ensure the availability and use of intravenous solutions as a part of emergency supplies. Item #1 Emergency Supplies Findings: 1. On 7/11/2016 at 2:00 PM during a tour of the South nursing station, Surveyor #3 noted that Code Blue, medical emergency bag did not contain intravenous solutions. The surveyor asked a nurse (Staff Member #4) about the availability of intravenous fluids for administration in the event of a patient medical emergency. S/he stated that intravenous fluids were in the pyxis on each unit. Staff Member #4 proceeded to discover there was no intravenous solution in the pyxis, this was confirmed with a call to the pharmacist, who reported that there is only one intravenous bag and it is located in the cart that resides on East Unit, which is temporarily housing patients from another facility, thus not readily available to this	L1165		

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L1165	Continued From Page 8 unit. 2. In review of policies titled, "Code Blue" (Policy #1000.13, Rev. 11/2015) and "Major Medical Emergency Treatment" (Policy #1000.12, Rev. 11/2015), it was noted that the procedures did not address the location of emergency supplies for patient care in medical emergencies. Item #2 Checking Emergency Supplies Findings: 1. Review of "Emergency Medical Equipment Daily Checklist" and the "House Supervisor Equipment Checklist & Audit" revealed omissions to both checklists. 2. The "Emergency Medical Equipment Daily Checklist" included hands on validation of the Oxygen tank, vital signs monitor, Code Grey Bag, Restraint Bag, PPE Bag, Safety Gown and Blanket readiness as well as other nourishments and supplies. Of the 11 days monitored, 1 day was blank on checks. 3. Review of the "House Supervisor Equipment Checklist & Audit" revealed weekly omissions to the checking of the 4 Automatic External Defibrillators and accompanying supplies. 4. Interview with the Chief Nursing Officer (Staff Member #3) confirmed the above findings and further reported the "House Supervisor is new" and upon questioning reported "s/he forgot".	L1165		
L1250	322-200.3C RECORDS-PSYCH EVALUATION WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry	L1250		

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L1250	Continued From Page 9 and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (c) Psychiatric evaluation including: (i) Medical and psychiatric history and physical examination; and (ii) Record of mental status; This RULE: is not met as evidenced by: Based on observations and review of medical records, the hospital failed to ensure History and Physical records were signed in 2 of 17 clinical records reviewed. Findings: On 7/13/2016 at 10:00 AM, Surveyor #3 reviewed 17 clinical records and found Patients #5 and #7 were without a signed Medical History and Physical.	L1250		
L1260	322-200.3E RECORDS-SIGNED ORDERS WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders; This RULE: is not met as evidenced by: Based on observations and review of medical	L1260		

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L1260	Continued From Page 10 records, the hospital failed to ensure Practitioners signed physician's orders in 3 of 17 clinical records reviewed. Findings: On 7/13/2016 at 10:00 AM, Surveyor #3 reviewed 17 clinical records and found Physicians orders for Patient #7, #12, and #14 were not signed.	L1260		
L1300	322-200.3M RECORDS-DISCHARGE SERVICES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (m) A discharge plan and discharge summary. This RULE: is not met as evidenced by: Based on observation and review of medical records, the hospital failed to ensure discharge services were entered into 2 of 17 clinical records. Findings: On 7/13/2016 at 10:00 AM, Surveyor #3 reviewed 17 clinical records and found charts for Patients #8 and #12 without discharge summaries.	L1300		
L1305	322-200.4A RECORDS-DATE WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (a) Date; This RULE: is not met as evidenced by:	L1305		

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L1305	Continued From Page 11 Based on observations and chart reviews, the hospital failed to ensure clinical record entries were dated in 3 of 17 clinical records. Findings: On 7/13/2016 at 10:00 AM, Surveyor #3 reviewed 17 clinical records and found the Physicans orders for Patients #7, #12, and #14 were not dated.	L1305		
L1310	322-200.4B RECORDS-TIME OF DAY WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (b) Time of day; This RULE: is not met as evidenced by: Based on observations and chart reviews, the hospital failed to ensure chart entries included the time of day in 3 of 17 clinical records. Findings: On 7/13/2016 at 10:00 AM, Surveyor #3 reviewed 17 clinical records and found Physicans orders for Patients #7, #12, and #14 contained entries without time of entry.	L1310		
L1315	322-200.4C RECORDS-AUTHENTICATION WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (c) Authentication by the individual making the entry; This RULE: is not met as evidenced by: Based on observation and review of medical records the hospital failed to ensure the hospital staff authenticated entries in 13 of the 17 clinical records reviewed.	L1315		

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L1315	Continued From Page 12 Findings: 1. On 7/13/2016 at 10:00 AM, Surveyor #3 reviewed 17 clinical records with the following findings; a. Physician's orders for Patient #7, #11, #12, and #14 were not signed. b. Admit Assessments and Evaluations were un-signed and/or un-dated for Patients #2, #3, #8, #11, and #12. c. Progress notes for Patients #1, #2, and #8 and #11 were not signed, dated or timed. d. Consent for treatment was not signed, dated or timed by the staff on patient #11. e. Restraint and Seclusion order for Patient #10 was without the Registered Nurse signature, time and date of signature. f. The history and physical (H&P) for Patient #7 remained incomplete with missing information and for Patient #1 the H&P was without time and date of the signature 2. On 7/14/2016 at 9:30 AM, Chief Nursing Officer confirmed the above findings.	L1315		
L1365	322-210.3A PROCEDURES-MED AUTH WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws	L1365		

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L1365	Continued From Page 13 and rules, including: (a) Assuring professional staff who prescribe are authorized to prescribe under chapter 69.41 RCW; This RULE: is not met as evidenced by: Based on observation, interview and review of policies and procedures, the hospital failed to ensure pharmaceutical oversite for scheduled medications. Reference: WAC 246-873-080 ..."(7) Controlled substance accountability. The director of pharmacy shall establish effective procedures and maintain adequate records regarding use and accountability of controlled substances, and such other drugs as appropriate, in compliance with state and federal laws and regulations. (h) Controlled substances, Schedule II and III, which are floor stocked, in any hospital patient or nursing service area shall be checked by actual count at the change of each shift by two authorized persons licensed to administer drugs." Findings: 1. On 7/11/2016 at 11:30, Surveyor #3 with registered nurse (Staff Member #4) reviewed the medication room for the South patient Unit. On the med counter was a book labeled "Narc Book"; Staff Member #4 informed this surveyor that the book was for those "patients that were admitted with their own controlled substances; that the [controlled substances] were kept in a locked drawer and that they were supposed to be counted by two RN's each shift." a. The pages reviewed titled "CONTROLLED SUBSTANCES RECORD" revealed the following; b. Review of the log pages for 6/30/2016 to	L1365		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/14/2016

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L1365	Continued From Page 14 7/10/2016 presented no patient identifier other than the patient's handwritten name (Patient #13) on the upper right corner of each page. c. Each page held 1 week of days with corresponding lines for each shift; days, evenings, and nights. Each shift had 2 nurse signature lines. Of the 12 days reviewed, (36 shifts=72 nurse signatures) 17 signatures were missing on the "CONTROLLED SUBSTANCE RECORD". d. Review of policies titled; "Patient's Own Medications (POM)" (Policy #33, Rev. 1/31/2016), and "Controlled Substances" (Policy #100.48, Rev. 12/2015), failed to identify how patient's own controlled substances were to be accounted for and monitored.	L1365		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This RULE: is not met as evidenced by: Based on observation, interview, and policy and procedure review, the hospital failed to ensure compliance with the Washington State Retail Food Code (WAC 246-215) Findings: 1. The hospital policy titled "Handling Ice" (Policy #1600.6.5, Rev. 11/2015) states in part, "4.2. The scoop is stored in a covered plastic container on top of the machine." 2. On 7/11/2016 between 11:30 AM and 12:30 PM, Surveyor #1 and Surveyor #2 conducted an	L1485		

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L1485	Continued From Page 15 inspection of the hospital ' s dietary department and made the following observations. a. The surveyors observed an ice scoop resting on top of the ice machine rather than in a clean, protected environment per hospital policy and WAC 246-215. Reference: Washington State Retail Food Code, WAC 246-215-03333 (5) b. The surveyors observed a paper cup being used as a scooping utensil stored in a bin of rice rather than a handled utensil that can be properly stored. Reference: Washington State Retail Food Code, WAC 246-215-03333 (2) c. The surveyors observed bagged salads in the walk in refrigerator. The surveyors interviewed the Dietary Manager (Staff Member #5) on the washing procedures for the produce. She stated that the leafy greens were washed but the chopped and shredded salads were not. The packaging indicated that the produce was pre-washed but did not indicate if it was ready to eat. The dietary manager was unable to provide documentation indicating that the products were a ready to eat food. Reference: Washington State Retail Food Code, WAC 246-215-03318 (1) 3. On 7/12/2016 at 11:10 AM, Surveyors #1 and Surveyors #2 made the following observations during an inspection of the nourishment room on the first floor of the West Wing. a. A box of frozen juice containers was thawing in the handwashing sink, restricting staff and patient	L1485		

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L1485	Continued From Page 16 access. Reference: Washington State Retail Food Code, WAC 246-215-05270 (2) b. The packaging for the juice containers stated that the items were to be thawed at 38° F and stored at 38° F after thawing. The surveyors observed that these items were thawing at room temperature. The surveyors also observed these items being held at room temperature in the North Wing of the facility, rather than the holding temperature specified by the manufacturer.	L1485		
L1555	322-240.2 LAUNDRY-SEPARATE AREAS WAC 246-322-240 Laundry. The licensee shall provide: (2) Storage and sorting areas for soiled laundry in well-ventilated areas, separate from clean linen handling areas; This RULE: is not met as evidenced by: Based on observation, the hospital failed to ensure that clean and soiled linens were separated during storage. Findings: On 7/11/2016 at 2:25 PM, Surveyor #1 and Surveyor #2 observed pillows stored on a counter near the sink in the soiled linen room of the first floor of the West Wing. The pillows were for patient use and should be stored in a clean linen room to prevent potential cross-contamination.	L1555		